Referral and authorization

☐ Retroactive ☐ Date call/fax received by ____________________

☐ Referral ☐ Inpatient ☐ Outpatient
☐ **Standard authorization** (completed within 14 days of receipt.)

☐ **Expedited** (**Choose ONLY** if you are attesting that waiting for a decision under the standard time frame could place the enrollee's life, health or ability to regain maximum function in serious jeopardy. Completed within **72 hours** of receipt.)

Section 1 Patient information

*** Required information**

Name	Date of birth	OHP Client ID #	Group #
			10009552

Section 2 Healthcare provider/on call doctor information

Name*	Clinic phone	Clinic fax
TIN #	Contact	

Section 3 Specialist Information

Name*	Clinic phone	Clinic fax	
Clinic address	City	State	Zip
TIN #	Contact		

Section 4 Facility Information

Name*	Clinic phone	Clinic fax
TIN #	Contact	
Admit date	Discharge date	

Section 5 Additional authorization/referral information

ICID10 code/s					
HCPC code/s					
CPT code/s					
Date span requested ____________ to ____________		# of visits/inpatient nights requested		Is this for a second opinion? ☐ Yes ☐ No	
Comments					

Questions? Call 503-265-2940 or 888-474-8540

Ready to submit? *Mail:* P.O. Box 40384, Portland, OR 97240 *Fax:* 833-949-1886

eocco.com

For EOCCO use only:

Authorization number ______________________ Denial number ______________________

Eastern Oregon Coordinated Care Organization complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. ATENCIÓN: Si habla español, hay disponibles servicios de ayuda con el idioma sin costo alguno para usted. Llame al 888-788-9821 (TTY: 711). 注意：如果您說中文，可得到免費語言幫助服務。請致電 1-877-605-3229（聾啞人專用：711） 1568 (5/21)